

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-017911

STATE FILE NUMBER

FILED JUN 9 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2532

300  
1-57

|  |                                  |   |   |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Jackson</u>  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If in institution, Residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>               |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>Kansas City</u>  |                                  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | c. CITY OR TOWN <u>Kansas City</u>  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>1402 Summit</u>  |                                  | Length of stay in lb<br><u>35 yrs.</u>  | d. STREET ADDRESS (If outside city or town)<br><u>1402 Summit</u>                                 |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Mae</u> Middle <u>Ellen</u> Last <u>Pumphrey</u>   |                                  |   | 4. DATE OF DEATH<br>Month <u>5</u> Day <u>19</u> Year <u>1959</u>                                 |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWER <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>11-3-1896</u>  |
| 9. AGE (In years last b. day)<br><u>68</u>   |                                  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Saleslady</u>  | 11. BIRTHPLACE (City and state of county)<br><u>Loxue Haute, Indiana</u>                          |
| 12. CITIZENSHIP<br><u>U.S.A.</u>   |                                  | 13a. FATHER'S NAME<br><u>Rollie Wilkie</u>  | 13b. MOTHER'S MAIDEN NAME<br><u>unknown</u>   |
| 14. NAME OF HUSBAND OR WIFE<br><u>Charles Pumphrey</u>   |                                  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Year, or unknown) (If yes, give war or dates of service)<br><u>No</u>   |   |
| 16. SOCIAL SECURITY NO.<br><u>490-34-5515</u>  |                                  | 17. INFORMANT<br><u>Mr. Charles Pumphrey; 1402 Summit</u>   |   |
| 18. CAUSE OF DEATH (Enter only one cause pertaining for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u>                         |                                  |   | INTERVAL BETWEEN ONSET AND DEATH  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost.<br>DUE TO (b) _____<br>DUE TO (c) _____   |                                  |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)  |                                  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)  |   |
| 20c. TIME OF INJURY<br>Hour _____ Month, Day, Year _____<br>a.m. _____ p.m. _____  |                                  |   |   |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                                  | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |   |
| 20f. CITY, TOWN, OR LOCATION   |                                  | COUNTY  | STATE   |
| 21. I attended the deceased from _____, to _____ and last saw her alive on _____<br>Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated. |                                  |   |   |
| 22a. SIGNATURE (Degree or title)<br><u>Margaret A. Owens, Carmis</u>   |                                  | 22b. ADDRESS<br><u>1034 Rialto Bldg</u>   | 22c. DATE SIGNED<br><u>5-21-59</u>  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Removal</u>  |                                  | 23b. DATE<br><u>5-25-1959</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Mound Calvary</u>  |
| 23d. LOCATION (City, town, or county)<br><u>Kansas City, Kansas</u>  |                                  | 23e. (State)  |   |
| 24. FUNERAL DIRECTOR<br><u>Wilbert Funeral Homes; (24) J.L. Mc</u>   |                                  | 25. DATE RECEIVED BY LOCAL REG.<br><u>5-21-59</u>   | 26. REGISTRAR'S SIGNATURE<br><u>Irene Marshall</u>  |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

High H. Owens

vector, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed *B. E. Duleit* .....

Licensed Embalmer No. *4075* .....  
P. O. Address *L. P. 8 Mo* .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.